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A NOTE ON DENGUE FEVER

W.G. PRIDMORE

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of cases which he had been treating with large doses of quinine, and which he considered had benefited greatly in consequence. His results at that time agreed with mine and confirmed me more than ever in the malarial origin of *kala-azar* and the great value of quinine.

Rogers found malarial parasites in every case of *kala-azar* in the early stages, and also in the later stages of cases he was able to examine repeatedly, and Ross found them in the great majority of early cases. Why, therefore, it should appear strange to Dr. Bentley that these investigators should have omitted to discuss the possibility of the disease being analogous to Malta fever, I fail to understand. In favour of the malarial origin of *kala-azar*, I would mention that it has always been my practice to clear out of an infected line all cases of the disease and to place them in a camp some considerable distance from all contact with the outer coolie world. This, of course, necessitates the employment of a separate establishment of hotel cooks, paniwallahs and sweepers, who are attached to the camp, and at one time I frequently noticed that a number of these attendants sickened with, and even died of, *kala-azar*, among the number being three hospital assistants one of whom I lost. A rule was therefore made that every person who was brought into contact with the infected coolies should be given ten grains of quinine twice a week, and since this plan was adopted I have only had one case of *kala-azar* among the camp attendants. This case was the native compounder in charge of the camp, and he made an excellent recovery under quinine, his illness lasting four months. Now, I take it that if *kala-azar* is not of malarial origin, quinine would not be of much use as a prophylactic, and one is almost inclined to believe from the number of drugs Dr. Bentley has employed in the treatment of the disease, that he has not been sufficiently persevering in the use of quinine.

Most writers on Malta fever lay considerable stress on the fleeting joint affections met with in a large proportion of cases, and Dr. Bentley mentions joint pains in his clinical picture of *kala-azar*. I can only say in this connection that his experience does not agree with mine, for I do not remember ever having seen affections of the joints in a case of the disease.

In conclusion, I would like to add, that while in quinine we have a most valuable drug in the treatment of *kala-azar*, segregation of the sick is of the utmost importance, and where coolie lines are badly infected they must be abandoned at all cost. In this district where these tactics have been adopted, the results have been gratifying in the extreme, but the greatest care has been taken to allow none but healthy coolies and their families into the new lines.

A NOTE ON DENGUE FEVER.

By W. G. PRIDMORE,

CAPTAIN, L.M.S.,

Civil Surgeon, Bhamo.

THE Burmans appear to be familiar with the disease and call it "*Toke Kwe Ana*," "*a disease which ties one together as the hands and feet, or as the ends of a bow are drawn together.*" They have a legend that it visits the country every thirty years.

The epidemic arrived in Bhamo in June last, having travelled up the Irrawaddy Valley starting in Rangoon in May and visiting Mandalay during the early part of June. It is interesting to note this following of the important trade route. It is not unlikely that the epidemic originated from the Hongkong epidemic, of which Dr. Stedman writes in the *British Medical Journal* of July 12th, 1902.

Etiology.—I regret that I have been unable to experiment with mosquitos. Dr. Graham's experiments are interesting, but far from conclusive. The extreme infectiousness of the disease and rapidity with which it spreads, are against the mosquito theory. The mosquito was certainly not answerable for the following case, the second that came under my notice.

The first that I attended, probably the first that occurred in Bhamo, arrived on June 19th from Mandalay. He was a European and was quartered over a mile distant from my quarters. My little daughter, a child of three, who had not been exposed directly to the disease, sickened on June 28th and went through a typical attack of dengue. The infection in this instance must have been carried by myself. I had heard of no other case in the town. It is not wise to over-burden the mosquito, but if, by planting a few other diseases on him, we can dispel the apathy that exists, and stimulate authorities to exterminate the pests, a blessing will be conferred.

I have diligently searched for Graham's parasite in the blood of half a dozen of my dengue patients, using unstained films, with a negative result.

Incubation.—Three days has been the average incubation period in the Bhamo cases. My third case (my wife) developed symptoms three days after the second case, whom she nursed, was well. It is difficult to judge how long a case remains infectious. In this instance the incubation could not have been less than three days. Four days after my wife's (the third case) attack began, I myself was attacked.

Symptoms.—Excepting natives with very dark skins the secondary rash invariably appeared on the fifth or sixth day. With a very dark skin it is easily missed.

Adenitis, a symptom which Dr. Stedman in his account of the Hongkong epidemic does not

mention, and which text-books mention as a complication, or sequela, has been fairly constant in the Bhamo cases. In at least 75% enlargement and tenderness of the cervical, axillary, inguinal and supra-condylar lymphatic glands have accompanied or preceded the second rash. It would be interesting to know the experience of others in this respect.

FURTHER NOTE ON INTESTINAL SAND

By C. H. BEDFORD, D.S.C., M.D.

MAJOR, I.M.S.,

Chemical Examiner to Government, Bengal.

SINCE the publication of my previous note on the subject, Major D. M. Moir, I.M.S., has very kindly afforded me the opportunity of examining a sample of intestinal sand which was given to him in 1892 by Dr. Birch, formerly Principal of the Calcutta Medical College. Dr. Moir was unable to give me any clinical facts in connection with the case, as he had not himself seen the case which was under Dr. Birch's care.

The quantity of sand placed at my disposal amounted only to a very few grains, and hence it was impossible to subject the specimen to a full quantitative and spectroscopic examination, as there was only enough for microscopical examination and the determination of the proportions of organic and inorganic constituents.

The result of analysis was as follows:—

Moisture	3.94 per cent.
Inorganic matter ...	7.62 " "
Organic matter	88.44 " "

The amount of inorganic matter present in this specimen accords more closely with what has already been observed in samples of so-called "false" intestinal sand. In my previous paper I mentioned the fact that generally 2 to 3 per cent. of inorganic constituents had been found in specimens of "false" sand.

The microscopic examination of this sample, taken along with the action of various reagents on the specimen when under the microscope, gave identical results with those obtained with the specimen described in my previous note.

I am, therefore, inclined to regard this specimen as one of "true" intestinal sand containing an unusually small proportion of inorganic constituents.

In conclusion, I take this opportunity of again thanking Major Moir for his kindness in sending me this specimen for analysis. Its examination—incomplete as it necessarily was—points to the difficulty of differentiating specimens of "true" and "false" intestinal sand by means of their relative proportions of inorganic constituents, and further seems to show that the proportion of inorganic matter may be much lower than has been hitherto supposed in specimens of "true" intestinal sand.

SIX CASES OF MELANCHOLIC STUPOR.

By E. F. W. EWENS.

CAPTAIN, I.M.S.,

Superintendent, Panjab Lunatic Asylum, Lahore.

I GIVE a summary of six cases of melancholic stupor or melancholia attonita or psychocoima as it is sometimes called that have occurred in this asylum during the past two years, not that there is anything new in them but that some of the cases are very typical of their kind, and all present such a distinctly marked clinical variety of insanity as to be well worthy of particular notice. (1) The first case is that of an unknown male admitted on 17th April 1901, apparently about 30. This man was arrested by the police, having been found wandering about cantonments, silently breaking flower-pots and window panes, nothing was known of him or could be discovered; while under observation he quickly passed into a condition in which he was stated to have lain continually on his back with the eyes closed quite motionless except for some twitching of the facial muscles, he never spoke, asked for nothing, and only eat food actually placed in his hands, and latterly certainly passed all his excreta where he lay. These were all the facts received with him on his admission. From that time and up to the present day (with an exception of a few days in May 1901 when he only differed by eating a little of his own accord) this man has never altered in one single particular. Though not deformed, not paralysed, with no sign of physical disease, he lies and has lain ever since on his side half-coiled up, absolutely motionless, never speaking, never moving, paying absolutely no attention to anything, flinching perhaps a little at some painful stimulus, but giving no other reaction. He is of a peculiarly yellow sallow complexion, and the mucous membranes are slightly anæmic, the eyes are tightly shut, and there is a distinct sense of resistance when they are forcibly opened, just as there is to any movement of the limbs or body, so that if it is desired to move him he has to be dragged or carried; the urine and excreta are passed under him, and he pays no attention to their presence, nor does he to the prolonged absence of food, which, however, he swallows when placed in his mouth. The reflexes are all normal, and his general bodily development as a result of regular forcible feeding still retains a good condition, and except for the complexion and colour and a certain amount of coldness and blueness of the hands and feet and the fixation of the face muscles in an expression of profound dejection there is nothing else noteworthy.

It is obvious that his position and quietude are voluntary, for he gives a distinct passive

